Medicare Rx Update: January 9, 2006

Medicare Rx… providing solutions and moving forward

Since the benefit went live on 1/1/06, CMS has been in constant contact with plans, independent and chain pharmacies, pharmacists, pharmacy organizations and advocates to identify and address issues as they have arisen. We are definitely making progress and pharmacies around the country are reporting that they are seeing improvements every day. Some of the steps we have taken include:

- E1 response times. Response time delays were addressed early last week and we are now consistently running at a response time of well under 1 second with no time outs. With much more data in the system, "hit rates" are also improving as data augmentation continues. NDCHealth will be sending additional guidance to pharmacies to assist in improving efficiencies in pharmacy match rates.

- CMS Pharmacist Help Line. CMS expanded the dedicated pharmacist help line for eligibility and enrollment information (1-866-835-7595) to be open 24 hours a day, 7 days a week. Also, CMS increased staffing of the pharmacist help line from 150 to 4,500 customer service representatives to handle the additional volume and reduce wait time. Using this line, pharmacists can determine plan enrollment status as well as whether the beneficiary is eligible for a LIS co-pay (*see: WellPoint for CSR-Pharmacist.doc*). Remember, when calling this number, you must provide the beneficiary's name, Medicare ID, date of birth and address. Unlike the E1, the HICN alone will not be sufficient on this line.

- Overloaded plan help desks. CMS and plans worked to improve processes for addressing beneficiary issues at the pharmacy. In addition to improving pharmacy phone support, we addressed plan submission of enrollment data, processing of acknowledgement letters and more (*see: Pharmacist help letter.pdf*).

- Transition policies. Late last week, CMS contacted plans regarding miscommunications about plan transition policies (*see: Transition policy reminder.pdf*). We stressed that delaying or denying the filling of initial prescriptions for new enrollees at the point-of-sale is not consistent with the intent of CMS' transition policy. For easy reference, the attached charts contain basic information to outline plan transition policies (PDP, MA).

- Establishing a process for emergency situations. If for some reason a person at a pharmacy cannot obtain their life-saving prescriptions and the current alternative methods do not allow the person to obtain their drugs, the person and/or their pharmacist can call 1-800-Medicare. The customer service representative will refer the case to a special regional office inbox. The regional office staff will have special access to the plans in order to obtain the necessary information, such as an override to the billing system that will enable the person to obtain their prescriptions.

- Pharmacy Open Door Forum. Last week pharmacists were loud and clear that they have specific questions to ask and precious little time to spend on a phone call with CMS. Therefore, we have scheduled an open door forum for

pharmacists with live Q&A on Tuesday, January 10, 2006, at 2 PM EST. To participate, please call 1-800-837-1935 and reference conference ID 3100979. A recording of this call will be available; beginning 2 hours after the call has ended. To access the recording, call 1-800-642-1687 and use the same conference ID (3100979).

Additionally, CMS has been working around the clock with plans to solve basic information and data issues that have resulted in some incorrect co-pay, coinsurance and deductibles for dual eligible and low income subsidy individuals. We are addressing these issues with individual plans and we are making progress by the hour.

Coping with and adjusting to change… especially new benefits for duals and LIS

Beneficiaries with dual eligible or low income subsidy status are unique in private third party plans and require special attention from all involved in the process of delivering their benefits. Some pharmacists are still reporting that they do not know what to do in certain circumstances pertaining to dual eligible beneficiaries. We have developed a short tip sheet to assist pharmacies with servicing these beneficiaries (*Dual one pager.doc)*.

Also, to assure that no dual eligible beneficiary leaves the pharmacy without their drugs, we have a Point of Sale Facilitated Enrollment Policy solution for pharmacists. Also attached is a shorter tip sheet for pharmacists on how the process works (*WellPoint for CSR-Pharmacist.doc*).

We are grateful to the many pharmacists who are contacting us with issues and we will continue to address them as quickly as they are identified. The following two items regarding excluded drugs and plan limits were brought to our attention in the form of helpful tips that could immediately help reduce pharmacy level processing frustration and call center volumes:

- When you receive a “drug not covered” message for a drug that was previously covered by Medicaid but is excluded with Part D, especially with regards to benzodiazepines and folic acid, pharmacists should bill to Medicaid after they receive the reject from the PDP.

- The message "plan limits exceeded" is due in many cases to Medicaid having covered a 31 days of supply while the PDP is covering only 30 days of supply. Pharmacists should change the quantity and days of supply for reprocessing before calling the plan for help.

Thanks again for your patience… progress is being made

With the first week of implementation behind us, millions of prescriptions have been dispensed to Medicare beneficiaries across the country. We are well on our way to resolving many implementation issues. We have made significant progress each day… and we will continue to make more progress in the days ahead. Thanks again for all you are doing to make this benefit a success.

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CENTER FOR BENEFICIARY CHOICES

January 4, 2006

TO: Medicare Part D Plans

FROM: Cynthia G. Tudor, Ph.D., Acting Director Medicare Drug Benefit Group

SUBJECT: Information to Assist Pharmacists in Completing Pharmacy Transactions

Congratulations! We all made it through the initial weekend of the Medicare Part D benefit, with many beneficiaries receiving their prescriptions without delay. The TrOOP Facilitator, NDCHealth, is now fully operational and providing excellent response times to pharmacist E1 queries. Now we need Part D plans to make greater efforts to assist pharmacies in getting the information they need to fill prescriptions on ALL of your enrollees.

We know that you are working hard to address start-up issues that have been identified in operations, as well as data inaccuracies. As these efforts continue, we need you to develop workarounds or shore up systems already in place to ensure that all beneficiaries get their prescriptions filled at the point-of-sale. Based on information we are receiving from you and from pharmacies, we need plans to immediately make improvements in the following 7 areas:

1. Customer Service Representative (CSR) Line Availability: In some cases plans experienced substantial backups at their Customer Service Representative (CSR) lines. In a number of instances reported to CMS, pharmacists who were attempting to fill an enrollee's prescriptions either could not get through to a CSR to obtain an acknowledgement of the beneficiary's enrollment in the plan or alternatively, had to remain on the telephone line for a protracted amount of time in order to obtain the necessary information to fill the prescription. We need plans to increase capacity on plan help lines, in general, and we need plans to identify a technical assistance number (for instance, a help desk supported by the PBMs or CSRs with access to PBM systems) that will be able to support these calls without redirection. We are adding this new Pharmacy Technical Help Desk contact to the Contract Management Module in HPMS; see more on this in item #5 below.

2. CSR Line Technical Assistance: Pharmacies have reported that when they do get through to customer service lines, many CSRs are not providing the "4Rx" data need to bill the member's claim. It is not appropriate for plan CSRs to refer such questions to the TrOOP Facilitator and the E1 query. Pharmacies contact the plans because the plans and/or their processors are the issuers of the 4Rx data, the most important one of which is the CardholderID, a mandatory billing element in the NCPDP 5.1 pharmacy transaction. Plans are the back-up to the E1, and since the E1 is easier to use than calling the plan, pharmacists can be assumed to have exhausted

this option when they call the plan – consequently these calls must be supported by plan CSRs. Again, we would like plans to identify a technical assistance number (for instance, a help desk supported by the PBMs or CSRs with access to PBM systems) that will be able to support these calls without redirection.

In addition to providing the 4Rx data, CSRs supporting the technical calls should be able to provide information on dual eligible and LIS copays (see item #3 below), nursing home copays, and correct information on transitional coverage of non-formulary drugs. We continue to receive numerous reports that plan CSRs are not aware of their plan's transition policies and that plans are inappropriately denying some scripts.

3. Providing Information on LIS Cost Sharing: If plans are aware that a beneficiary is subsidy-eligible, but do not know the exact subsidy level, they should default the enrollee to a $2/$5 benefit package. If they have no information indicating that the beneficiary is subsidy-eligible, they may default the enrollee to the base non-subsidized benefit package, however—

Even with these defaults in place, plan CSRs who answer pharmacist calls should be trained and prepared to assist pharmacists with overriding default benefit packages in the event that an enrollee presents at the pharmacy with evidence of dual eligibility or an SSA subsidy determination.

Even if a plan has not yet received the weekly TRR, it can still obtain information on LIS status from the following sources:

- CMS Batch Status Summary Reports (these are generally sent out within 48 hours of receipt of the enrollment transactions)
- CMS Drug Plan Finder web tool - (available status limited to either "no more than $2/$5" or "15%")
- 1-800-MEDICARE - (available status limited to "no more than $2/$5" or "15%")
- Speaking with the beneficiary about an auto-enrollment or SSA letter.

4. Prompt Submission of 4Rx Files to CMS: Many pharmacies have automated their billing based on the E1 eligibility data. Therefore the sooner plans can submit their 4Rx files to CMS, the faster complete data can be available from the E1. To date, CMS has not established a deadline for submission of the 4Rx files. However, given the delays we are experiencing in receiving these files, we must now establish a requirement that plans submit the 4Rx files to CMS **within 48-72 hours** of receiving confirmation of enrollment on the TRR. Plans should begin to adhere to this schedule no later than Monday January 9, 2006.

5. Reporting of 3Rx Data to CMS: CMS is rethinking the 4Rx submission process and, as a preliminary step, we will now require that plans enter certain data, including the RxBIN, RxPCN and/or RxGRP for each plan ID, into an HPMS screen that will be available no later than noon EST on January 5, 2006. **Please complete this HPMS data entry by close of business on Friday, January 6, 2006**. This data must be maintained and prospectively updated in HPMS in the event of any change of processing arrangements. It is absolutely critical that this information is maintained, is up-to-date, and accurately reflects your various plans' processing arrangements

and whatever information you are publishing via your payer sheets. Please note that this does not replace the current requirement to send in 4Rx files, as described in item #4 above.

The data elements we need entered into HPMS include the following:

- For each contract number, we are requesting the RxBIN, RxPCN, and RxGroup for EACH of the plan benefit packages (PBPs) (or plans). (If the plan sponsor or its claims processor cannot break out the PBP at the PCN level and needs to report at the RxGROUP level, then the information must be submitted at the level of granularity for a "plan.")
- For each contract number, you must enter the Pharmacy Technical Help Desk contact information, including a telephone number, into the HPMS Contract Management Module.
- For each contract number, you must enter the Processor contact information, including a telephone number, into the HPMS Contract Management Module.

CMS will send an e-mail to all Part D plans with further technical instructions on how to complete these tasks in HPMS.

6. Improved Communication with Network Pharmacies and CSRs on Acknowledgement Letters: Since enrollments can be received until the last day of the month, it is very important that your network pharmacies and CSRs understand their responsibility to support the CMS requirements with respect to honoring acknowledgement letters. Plans must clearly communicate to their contracted provider networks that these letters must be accepted and used for billing claims in advance of the distribution of plan ID cards. CSRs answering pharmacist calls must be trained in assisting pharmacists with understanding their responsibility and with obtaining the 4Rx data needed for proper billing if this data is not contained in the acknowledgement letters. We expect plans to broadcast notices to their network pharmacies on proper use of the acknowledgement letter, and ensure that CSRs are adequately trained.

7. Earlier Submission of Enrollment Transactions: In order to avoid processing delays at month-end, plans should submit enrollment transactions on a flow basis. Plans must also improve their procedures and systems for downloading enrollments from the Online Enrollment Center. To the extent possible, please submit all available February enrollments to CMS by the February payment cut-off date of January 13, 2006. For best results, submit enrollments to CMS on a daily basis. Prompt submissions improve the quality of the data available to pharmacists at the point-of-sale.

If you have questions about these requirements, please contact the MMA Help Desk or your CMS plan account manager. Thank you.

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CENTER FOR BENEFICIARY CHOICES

January 6, 2006

Memorandum To: All Part D Sponsors

Subject: Pharmacy Transition Policies

From: Gary Bailey, Deputy Director, Center for Beneficiary Choices

As we move to the end of the first week of implementing the Medicare Drug Benefit, we need to remind all Part D sponsors again of the transition policy requirements that must be upheld. It is critical that transition policies operate in a manner that ensures enrolled beneficiaries get their needed first prescriptions filled at the point-of-sale.

As we noted in recent letters and plan user calls, we continue to receive numerous reports that plan customer service representatives (CSRs) are not aware of their plan's transition policies. We must emphasize that sponsors need to ensure that their member/customer service representatives are trained to respond to questions about the transition policies of their organization. They should not be informing beneficiaries that the plan does not have a transition policy or indicating that access to non-formulary drugs can only be provided via the exceptions process. Of greater concern, however, are reports that plans are inappropriately denying some prescriptions because the plan has not provided transition override instructions to pharmacists. Sponsors need to ensure that their network pharmacies are provided appropriate instructions on how to implement the filling of a transition supply in a manner that is consistent with the plan's transition policy approved by CMS.

We have also received a number of complaints regarding the use of potentially burdensome prior authorization and step edit requirements that are preventing access by beneficiaries to needed first prescriptions at the point-of-sale. This also applies with respect to covered drugs on formulary for which the plan has a step edit or prior authorization requirement. As we have emphasized on previous plan user calls, we expect that Part D sponsors will use sound business and clinical decision making when administering transition supplies and not place undue burden on beneficiaries during the implementation of the benefit. We expect the provision of drugs under your benefit will be such that the enrollee will either have a step edit or prior authorization requirement resolved at the point-of-service, or the enrollee will have access to a temporary supply until such requirements can be met for either formulary or non-formulary drugs. While transition policies are not intended to cover excluded drugs or to preclude drug utilization review edits for safety, we must stress that delaying or denying the filling of initial prescriptions for new enrollees at point-of-sale because of prior authorization/step edit requirements is not consistent with the intent of CMS' transition policy. Thus, as a general

matter, prior authorization and step edits should be suppressed so as to not prevent an enrollee from receiving their medications under a transition period.

Finally, we are also hearing confusion over transition issues involving long term care (LTC) residents, including issues involving the transition period and the intersection of Part B versus Part D drug coverage. To reiterate our transition guidance published last March, it is critical that the plan's transition process address access to medications at the filling of the first prescription for enrollees who are LTC residents and that plans take into account polypharmacy circumstances involving these enrollees. We were pleased that plans adhered to our guidance and indicated they would provide a longer transition period for enrollees who are residents of LTC facilities. We expect that all plans will honor their transition process in order to safely accommodate new enrollees under their plan's formulary. Again, we need to stress that prior authorization and step edits should not prevent an enrollee in an LTC setting from receiving their initial medications.

As we note in our *Medicare Part B versus Part D Coverage* document on the CMS website, Part D does not alter Part A or B coverage. However, drugs that were not covered by Part B for LTC residents before the implementation of the Part D benefit may now be covered under Part D. In particular, the Medicare Part B durable medical equipment (DME) benefit covers a limited number of drugs that require the use of an infusion pump "in the home" and covers inhalation drugs that that require the use of a nebulizer "in the home." Certain LTC facilities are not considered a "home" for the purpose of the DME benefit, and thus when DME drugs are administered in these facilities, they would have coverage under Part D. Facilities that are not considered a home include a skilled nursing facility (SNF), a distinct part SNF, a nursing home that is dually-certified as both a Medicare SNF and a Medicaid nursing facility (NF), a Medicaid-only NF that primarily furnishes skilled care, a non-participating nursing home (i.e. neither Medicare or Medicaid) that provides primarily skilled care, or an institution which has a distinct part SNF and which also primarily furnishes skilled care. Enrolled beneficiaries in these facilities who require DME drugs would have coverage under Part D to the extent that they are not covered under Part A.

In addition to DME drugs, Medicare Part B also covers a number of infusable or injectible drugs that are administered incident to a physician service. If a LTC facility, rather than a physician, administers such a drug to a beneficiary (whose stay is not covered under part A), the drug would not be covered by Part B, and the beneficiary would have coverage for the drug under Part D subject to the Part D plan's rules or transition policy for first fills. For more information, we refer you to our guidance at http://www.cms.hhs.gov/PrescriptionDrugCovContra/Downloads/BvsDCoverage_07.27.05.pdf.

As you know, it is in the interest of both plans and CMS that the enrollee's initial experience with the Medicare Drug Benefit be free from undue administrative problems. We know we can continue to count on your hard work to resolve the transition issues as soon as possible.

Quick Answers to FAQs on Processing Claims for Dual Eligible Beneficiaries

- **What if a dual eligible beneficiary (Medicare and Medicaid) presents at the pharmacy and does not know what plan he or she has been auto enrolled in?**

  The pharmacist should send an E1 query to determine Part D plan enrollment. If the E1 query returns the RxBIN-RxPCN-RXGrp-RxID (the "4Rx" data) and 800 number of a Part D plan, the pharmacist should bill the plan. If the E1 query returns just the 800 number of the plan, the pharmacist should call the 800 number to obtain the billing information from the plan. If the E1 query returns no match, the pharmacist should check for Medicare eligibility by submitting an expanded E1 query and Medicaid eligibility through the patient history, a Medicaid card, or a current Medicaid letter. Pharmacists can also call a dedicated pharmacy eligibility line at 1-866-835-7595. The pharmacist may use the Point of Sale facilitated enrollment solution once dual eligibility is determined and plan enrollment cannot be identified (see last bullet).

- **What if a dual eligible beneficiary who has been auto enrolled presents at a pharmacy with a plan acknowledgement letter indicating that the beneficiary has switched plans?**

  If the person does have their plan acknowledgement letter in hand, that letter should include the RxBin, RxPCN, RxGrp and RxID, generally in the upper left hand area above the greeting. The pharmacist should use that information for billing or, if the letter does not include this information, the pharmacy should call the plan to get the information needed to send in a claim.

- **What if a dual eligible beneficiary who has been auto enrolled presents at a pharmacy without a plan acknowledgement letter, but indicates that he or she has switched plans?**

  The pharmacist should send an E1 query or call the dedicated pharmacy eligibility line at 1-866-835-7595 to determine Part D plan enrollment.

- **What if a beneficiary presents at a pharmacy with a Medicaid card and appears to be Medicare eligible, but the pharmacist cannot determine that the beneficiary has been auto-enrolled in any plan?**

  Once the E1 query has failed and the pharmacist has reasonable basis for believing the beneficiary is dually eligible, the POS Contractor (Anthem) should be billed. This will allow for the prescription to be filled and begin the process of enrolling the dual eligible beneficiary into a Part D plan.

Please see "What If Scenarios for Pharmacy" for a more detailed list of FAQs.

For CSR describing the POS "WellPoint" process to a pharmacy:

The Point-of-Sale (POS) Facilitated Enrollment process is for providing immediate coverage of Part D drugs to dual eligible individuals who have not already been auto-enrolled into another Part D plan. Most dual eligible individuals have been auto-enrolled, so you should first check for enrollment in a Part D plan by asking for a plan ID card, other documentation from a Part D plan, or submitting an E1 query.

Questions concerning the E1 process should be directed to the TrOOP Facilitation Help Desk at NDCHealth at 1-800-388-2316 instead.

If your customer says they are enrolled in a plan but don't have their card yet (or an acknowledgement letter) and E1 does not show the enrollment yet, you should contact Medicare's dedicated pharmacy enrollment line (1-866-835-7595) available Mon.-Fri. 8 AM-8PM EST; or 1-800-MEDICARE (available 24/7) to find out how to contact the plan.

(When calling the dedicated pharmacy line or 1-800 MEDICARE, you must provide the beneficiary's name, Medicare ID number, date of birth, and address. While the HIC number alone may be used for eligibility (E1) queries to the TrOOP Facilitator, all 4 pieces of information are needed for phone inquiries.)

To Use the POS process: If you cannot find evidence of a Part D plan enrollment AND you can confirm reasonable evidence of both Medicare and Medicaid eligibility, you may bill the POS Contractor for the claim.

To verify Medicaid eligibility: In addition to existing state resources, such as IVR systems, you can use the following as verification of Medicaid eligibility:

- Medicaid ID card
- Recent history of Medicaid billing in the pharmacy patient profile
- Copy of current Medicaid award letter

To verify Medicare eligibility: You can check for either Part D enrollment **or** eligibility for Medicare Parts A & B by submitting an E1 query to the TrOOP facilitator.

Other (offline) ways to check for A/B Medicare eligibility are:

- Request to see a Medicare card; or
- Request to see a Medicare Summary Notice (MSN); or
- Call the dedicated Medicare pharmacy eligibility line (1-866-835-7595); or
- Call 1-800-MEDICARE

To Bill the POS Contractor: Make sure you have first submitted an E1 query and ruled out evidence of enrollment in a Part D plan, then:

There are mandatory data elements that must be included on the claim, including both the Medicare and Medicaid ID numbers. All claims generated by the POS process must be billed in accordance with the WellPoint (Anthem) payer sheet that is available at:

http://www.anthem.com/jsp/antiphona/apm/nav/ilink_pop_native.do?content_id=PW_A081085

If you need more information after reviewing the payer sheet, you can contact the Anthem pharmacy help desk at 800-662-0210, as indicated on the payer sheet.

ID Numbers: You will have to submit the beneficiary's Medicare ID number (known as the HICN), as well as the Medicaid ID number. Both numbers are critical to rapid verification of dual eligibility and should be available from all the valid sources of Medicaid or Medicare eligibility verification.

If your pharmacy's systems do not currently support the entry of more than one ID number into the B1 record, there are two workarounds:

1. Enter the Medicaid ID in the Group ID field [301-C1] of the insurance segment AND bill a separate payer account: BIN: 610575; PCN: CMSDUAL**02**;

or

2. Enter the Medicaid ID in the Group ID field [301-C1] of the insurance segment AND include the Patient ID Qualifier field [331-CX] AND program the pharmacy system to map the Group ID field to the Patient ID field in the creation of the B1 transaction

Edits: There are no edits for Non-Formulary Drugs, or for Prior Authorization or Step Therapy. However, drugs excluded from Medicare coverage will not be paid for.

Copays: The claim will always process at a $1/$3 copay level.

Quantity Limits: The POS process will allow up to a 14 day fill, but you may elect to fill less than a 14 days supply at your discretion. We expect dual eligible individuals who are not already enrolled in another plan to be enrolled into a WellPoint (UNICARE) plan by the end of 14 days.